STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145256	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeland Rehab & Healthcare Center	800 West Temple Street Effingham, IL 62401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49907 Based on interview, and record review the facility failed to ensure residents were safe from misappropriation of a controlled substance medication for 1 of 3 residents (R2) reviewed for misappropriation in a sample of 8. The findings include: R2's facility Initial Report dated 8/20/24 documents in part: The purpose of this letter is to notify The Department of a possible drug diversion. It was noted that resident Received his 8am dose of morphine but when the nurse went to give the 10 am dose the morphine could not be located. All notifications have been made. The facility has initiated an investigation into the matter. A final report will follow. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's facility Final Report dated 8/26/24 documents in part: The purpose of this letter is to notify The Department of our conclusion of the investigation into a possible drug diversion. Licensed staff had administered the resident's 8 am dose. At 10 am when the Licensed Nurse went to administer the morphine, the bottle of morphine could not be located. The physician, POA (Power of Attorney), (City) Police and the Ombudsman were notified. The Administrator and Nursing Administration initiated a search of the facility and facility grounds. The medication was not located. An investigation was initiated. The Licensed Nurse, (V4) was overseeing the medication cart. He was suspended pending the outcome of the facility. The hospice nurse was notified of the Morphine bottle not being located. The facility asked Hospice to replace the Morphine and bill the facility. The Morphine was replaced. Licensed staff initiated a pain assessment. (R2) showed no changes in his pain level. Residents were interviewed. Residents were not aware of any issues with medications and had not observed the medication. All staff working were interviewed. Staff stated that they had not observed the morphine out of the cart and had no knowledge of where the medication was. (V11) LPN (Licensed Practical Nurse) was the night shift nurse and was still working till approximately 10:30 am finishing the charting for her shift. (V11) stated that the medication cart was in front of the nurse's station. She stated that (V4) had administered the 8 am dose of Morphine. (V11) said that she did not observe (V4) place the Morphine bottle in the cart and lock it as she had her back to him charting at the nurse's desk. (V11) stated at approximately 10:00 am (V4) went to the medication cart to administer the 10:00 am dose of Morphine and he stated it was not in the cart. She stated that he began looking for the medication and Nurse Management was notified. (V11) was asked if she observed the bottle of Morphine on top the cart and she stated No, she did not. She was also asked if the medication cart was locked. She stated that she was finishing charting, and her back was toward the cart. (V4) LPN was interviewed by the Director of Nursing and Regional Nurse via phone. He stated that he had given the resident his 8 am dose of medication. (V4) stated he placed the empty syringe back into the morphine box and placed everything in the medication cart and locked the cart. He stated that at approximately 10 am he went to the cart, unlocked the cart, and was going to give the medication but was unable to locate the morphine in the cart. (V4) stated that he searched the cart and could still not locate the medication. He stated that he checked the trash can on the med cart and at the nurse's desk. (V4) stated that he checked the second medication cart and the treatment cart but was not able to locate the medication. He then notified Nurse Management and Nurse Management began looking for the Morphine. (V4) was asked if he placed the medication back in the cart and locked the cart after administering the 8 am dose and he said yes, that is my routine. He was asked if he unlocked the cart when he was getting ready to administer the 10 am dose and he said yes. (V4) said after he was sent home, he was retracing his steps in his head and was second guessing everything he did. (V4) denied taking the medication and volunteered for drug testing. (V4) submitted a drug test, and the results were negative. An audit of all narcotics in the facility was completed and no other issues were noted. Following the investigation, based on interviews, the facility is not able to determine what happened to the morphine and cannot substantiate drug diversion. There is no evidence indicating (V4) took the medication. The facility is unable to locate the Morphine, and the search is ongoing. The morphine was replaced at the cost of the facility. All Licensed staff were educated by the Director of Nursing regarding Medication Administration, medication storage, and narcotic count between shifts. (V4) will be allowed to return to work. Prior to returning to work, the Director of Nursing completed education regarding Medication Administration, medication storage, and narcotic count between shifts. R2's admission record documents an admitted [DATE] and a discharge date of [DATE]. with diagnoses in part; encounter for palliative care (admitting diagnosis), atherosclerotic heart disease, chronic obstructive pulmonary disease, chronic kidney disease, heart failure, chronic pain, colostomy status, cervicalgia, osteoarthritis, chronic pulmonary embolism. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's order summary report documents in part an order dated 7/29/24, resident is under Transition hospice care. R2's Medication Administration Record (MAR) for September, with a print date of 10/8/24 documents an order for Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML (Morphine Sulfate) Give 0.5 ml by mouth every 2 hours for pain with a start date of 8/24/24. R2's MAR documents that he received his scheduled doses of Morphine at 8:00 and 10:00am on 9/20/24. A facility document titled INDIVIDUAL RESIDENT CONTROLLED SUBSTANCE RECORD dated 8/19/24 with R2's name handwritten on it documents the medication as Morphine Sulfate 20mg/ml and the quantity received as 30ml. The last documented dose administered on this document is on 8/20/24 at 9:00am, the amount given is 0.5 with 24ml remaining. R2's ordered dose was 0.5mg, indicating there were 48 doses left in the bottle. On 10/8/24 at 12:03pm, V5 (Licensed Practical Nurse/LPN) stated she was here the day the morphine went missing, everyone was looking for it. It was never found. There was big investigation done and lots of education and inservice. On 10/9/24 at 12:29pm, V2 (Director of Nursing) stated as soon as they were alerted that morphine was missing, they contacted hospice and started the process of getting a replacement. V2 stated they received the medication very quickly; the pharmacy delivered it and R2 received the dose within the appropriate time frame. V2 stated R2 was being assessed for pain frequently while waiting for the replacement bottle. V2 stated the missing bottle was never located after a search of the property and investigation. On 10/9/24 at 03:15pm, V4 (LPN) stated there was no narcotic count completed between himself and V11 (LPN) after he took over the med cart. V4 stated he counted by himself at one point, and everything was fine. V4 stated he is certain he drew up R2's medication and locked the bottle back into the cart, as that is his common practice. V4 stated that since this incident happened, he has been replaying it in his mind and second guessing himself, however he stated he sees no reason why he would have done things any differently. V4 stated he was the only one suspended and investigated. V4 stated the other nurse working with him told him and administration there was a CNA that does transport standing by his cart, she then went to the bathroom and went to a patient room. V4 stated that this CNA was questioned, but not investigated. V4 stated the medication was never found. The Facility's Abuse, Prevention and Prohibition Policy revised 1/24 documents in part, This facility prohibits mistreatment, neglect, or abuse of residents. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. This presumes that all instances of abuse, even those residents in a coma, can cause physical harm, pain, or mental anguish. The facility also prohibits misappropriation of resident property.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49907 Based on interview and record review the facility failed to prevent residents from receiving medical treatment without a doctor's order for 1 (R1) of 3 residents reviewed for physician's orders in a sample of 8. Findings include: R1's admission record documents an admitted [DATE] with diagnoses in part; type II diabetes mellitus with hypoglycemia without coma, paroxysmal atrial fibrillation, other seizures, unspecified convulsions. R1's Minimum Data Set (MDS) dated [DATE] documents a BIMS (Brief interview for mental status) of 12, indicating that R1 is cognitively intact . R1's order summary sheet documents an order for ACCUCHECK every two hours from the ER (emergency room) for hypoglycemia with a start date of 3/4/24 and a discontinue date of 6/20/24. On 3/19/24 R1's Medication Administration Record documented accuchecks every two hours, most of R1's accuchecks were between 80 and 162, which is not considered to be hypoglycemic. There is an accucheck at 12pm of 46, which is considered hypoglycemia, but there is no further documentation in R1's clinical record, including progress notes. R1's order summary sheet documents an order for Glucagon Emergency Injection Kit, 1 MG (milligram) (Glucagon (rDNA))-Inject 1 application intramuscularly as needed for low blood sugar with a start date of 2/20/24. There is no documentation that the glucagon was administered on 3/19/24. On 10/8/24 at 1:40pm, R1 stated his blood sugars have been pretty good lately and he could not recall if anyone tried to start an IV on him in this facility. On 10/8/24 at 1:51pm, V2 (Director of Nursing/DON) stated they had an incident in March involving V3 (Licensed Practical Nurse/LPN) attempting to start an IV (intravenous) without a physician's order. V2 stated V3 was not successful starting the IV, no medications were administered, but V3 was disciplined, and staff education was done. V2 stated V3 had spoken with V6 (the nurse at the doctor's office) previously about this resident and V6 stated if R1 continued to have such drastic drops in his blood sugar they would need to get a standing order to give dextrose via IV. V2 stated V6 did not give a standing order at that time. V2 stated that they do not have a specific policy or protocol to low blood sugars, but each resident who is under blood glucose monitoring should have standing orders for such situations. On 10/08/24 at 1:51pm, V2 (DON) provided a copy of facility document titled Employee disciplinary action form for V3 with an incident date of 03/19/24 stated V3 did not follow departmental Policies and procedures. This document further stated that V3 did not get an order from MD prior to initiating a medical procedure/medication and that there was no documentation of residents low CBG (Capillary Blood Glucose). V2 provided a statement from V6 that she did not give a standing order for IV dextrose and a signature sheet from their staff in-service.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49907 Based on interview and record review the facility failed to provide adequate supervision for residents with dementia for 2 (R3 and R4) of 5 residents reviewed for dementia care services in the sample of 8. Findings include: A facility incident report dated and timed 9/15/24 at 11:08am, documents the following incident description in part: A Housekeeper helping another patient to her room walking in room [ROOM NUMBER]. When opened room [ROOM NUMBER] housekeeper witnessed (R4) standing in front of female patient with his pants open and down-with suspenders holding pants part way up. Female resident was in her room on her bed, fully clothed. Female patient had her mouth open providing oral sex to (R4). (R4) turned around and pulled up his pants, he told staff he was receiving help with is belt. Both patients immediately separated themselves, he went to his room. Female patient states she thinks (R4) is her husband and she wants to be with him. When staff asked (R4) if he knew her, he says he doesn't know her, just some lady around here. He said he needed help adjusting his belt. He denied what was going on. He asked if they were in trouble . An investigation was initiated following the interaction. Staff present at the time of the incident were interviewed. (R3) stated she didn't understand why staff won't let me be with my husband. Both residents were put on 1:1 for 24 hours after the incident. Both resident's Physicians were notified, and no new orders were received. There have been no further incidents. Residents were interviewed. The residents interviewed have had no issues with either of the residents involved. (R3) was interviewed. She does not recall the incident. (R4) was interviewed. He does not recall the incident. The Ombudsman was notified and stated that both parties were consenting. A trauma assessment was completed for both residents, identifying no new issues. Behavior tracking was initiated for both residents. Their care plans were reviewed and updated. Social services will visit with each resident twice weekly for 30 days. After reviewing the incident, it is our conclusion that during the incident both residents were consenting adults. A facility correspondence with IDPH titled Final Report dated 09/20/24 documents in part: The purpose of this letter is to notify The Department of our conclusion to a reported incident. On 9/15/24, staff observed an interaction between two residents, (R3) and (R4). Staff immediately separated the residents. Licensed Staff initiated a head-to-toe assessment noting no injuries. MD(Medical Doctor) and POA (Power od Attorney) made aware. Local police were notified. Ombudsman was notified. On 10/08/24 at 2:51pm, V1 Administrator stated that the incident on 9/15/24, between R3 and R4 was consensual, but provided no evidence during this investigation that R3 and R4 had been screened and identified as having the cognitive ability to provide consent. 1. R4's admission record documents an admitted [DATE] with the diagnoses in part: Alzheimer's disease, other symptoms and signs involving cognitive functions and awareness, altered mental status. R4's Minimum data set (MDS) dated [DATE], documents a Brief interview for mental status (BIMS) of 3, indicating that R4 is severely cognitively impaired. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's current care plan documents a focus area of inappropriate sexual behavior. With an initiation date of 9/16/24 and a revision date of 9/27/24 with interventions including in part: Behavior #1: Inappropriate sexual conduct towards others (i.e.: inappropriate touching, purposeful exposure of genitals to others, etc.) Remove from area, ensure (R4)'s safety, encourage to discuss feelings, try a different care giver, offer to call family. Monitor behavior episodes and attempt to determine underlying cause. R4's POC response history with a print date of 10/8/24 documents that R4 displayed inappropriate sexual conduct toward others on 9/24/24 and 10/1/24, intervention used for both occurrences was redirection. R4's progress notes document in part the following: On 9/15/24 at 1:42pm, (R4) was looking for female friend and went into her room looking for her .staff asked him to get out of her room and he became agitated. On 9/15/24 at 2:02pm, (R4) was standing outside lady friend's room, waiting on her to come to her room it appears. Staff asked him what he was doing. He said he's looking for someone. Asked to stay out of room [ROOM NUMBER]. Informed him 121 was a female room. He opened the door twice and was inside once. On 09/16/2024 at 4:20pm, SSD (Social Services Director) met with (R4) today and conducted BIMS, PHQ9 (Patient Health Questionnaire-9) , and trauma informed consent. (R4) states he feels safe in his environment. No other concerns at this time. On 9/22/24 at 2:48am, Resident was seen wandering into another resident's room, resident went into a female resident's room and was trying to wake her to leave, resident was redirected back to bed by staff, continue to monitor closely. Continue current plan of care. On 9/27/24 at 9:05am, Resident went into a female resident's room and was trying to get her to go with him. On 9/27/24 at 1:59pm, Resident was in another female resident's room. Redirected back to his room. On 10/1/24 at 10:01am, Resident tried to get female resident to go in his room. The other resident refused, and he stated, I guess you don't want to have sex with me. On 10/9/24 at 12:30pm, V8 (Registered Nurse/RN) stated it is known that they are supposed to keep a close eye on R4 but there really isn't anything specifically laid out in his care plan or behavior tracking related to his level of supervision. V8 stated that R4 was supposed to be one on one for the first 24 hours after the incident happened. V8 stated she was not familiar if there was anything that the CNA's were supposed to chart specifically but nurses were expected to chart on R4 any time a behavior is observed. On 10/9/24 at 1:15pm, V9 (Restorative Aide) stated that everyone on the unit is to be under close supervision. V9 stated he was not sure if there was any specific supervision in place for R4. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R3's admission record documents an admitted [DATE] with diagnoses including in part; Alzheimer's and dementia. R3's Minimum Data Set (MDS) documents a Brief Interview for Mental status (BIMS) of 07, indicating that R3 is severely cognitively impaired. R3's current care plan documents a focus area of inappropriate sexual behavior. With an initiation date of 9/16/24 with interventions including in part: Behavior #1: Inappropriate sexual conduct towards others (i.e.: inappropriate touching, purposeful exposure of genitals to others, etc.) Remove from area, ensure (R3)'s safety, encourage to discuss feelings, try a different care giver, offer to call family. Monitor behavior episodes and attempt to determine underlying cause. On 9/15/2024 at 11am, Roommate came to housekeeper and said she needed help getting in her room. Housekeeper was helping 121-2 patient back to her room, she knocked on the door 121 and opened it for roommate to walk in. Housekeeper witnessed (R3) sitting on bed fully clothed with her mouth open giving oral sex to a male patient. Male patient was standing in front of her with his pants open and down-with suspenders holding pants part way up. Male resident turned around and pulled up his pants, he said he was receiving help with is belt. (R3) and male patient immediately separated themselves, he went to his room. (R3)'s face was red. She appeared embarrassed. She asked why she can't be with her husband . (her husband is not here/alive) Re-oriented her that she is in nursing home and her husband is no longer around. (R3) insist we separated her from her husband and is asking why. (R3) said she brought him to her room. Male patient says he doesn't know her, just some lady around here he said . On 9/16/24 at 4:17pm, SSD (Social services director) met with (R3) today. Conducted BIMS, PHQ9 (Patient Health Questionnaire-9), and trauma informed consent. (R3) was very confused today and displayed disorganized thinking. She states she feels safe in her environment. On 10/9/24 at 1:21pm, R3 was observed ambulating down the hallway away from her room. R3 stopped and proceeded to stand in R4's doorway and then walked inside while R4 was laying on his bed. Staff was alerted and redirected R3. On 10/9/24 at 1:27pm, V10 (CNA/Certified Nursing Assistant) stated everyone on the locked unit is under close supervision. V10 stated R3 and R4 were both in the unit on 9/15/24. V10 stated R3 and R4 were both one on one supervision for the first 24 hours after the incident. V10 stated they really try to prevent anyone going into the room of someone of the opposite sex. V10 stated that they do chart behaviors if R4 has them, but that they do not have any specific time frame for checking on him. There is no documentation in R3 or R4's current clinical records of any discussion or education with them, their representative, or physician regarding consent. There is nothing in R3 and R4's care plans regarding consent. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility document titled, Abuse, Prevention and Prohibition with a revision date of 1/24, under the section titled Protection, The facility will immediately remove any alleged perpetrator from any further contact with any resident. Further on in this document in the section Resident capacity to consent to sexual activity it states generally, sexual contact is nonconsensual if the resident appears to want the contact to occur but lacks the cognitive ability to consent. This document states that if there are 2 residents who wish to have a sexual relationship, the following steps will be followed: A one-on-one discussion with each individual must be held to ensure they are consenting to an intimate relationship with the other resident. The discussion will define the type of relationship that is desired. For a resident who DOES NOT have the capacity to consent, the Resident Representative will be contacted to discuss resident wishes. If the Resident Representative DOES NOT AGREE with the resident choice, then there will be a resident, Resident Representative, IDT meeting to discuss plan of care. Provider will be notified of resident and Resident Representative wishes. Discussion and consents to be documented in the clinical record and care plan updated to reflect the resident and/or Resident Representative wishes. Education will be provided to both residents involved and when appropriate the Resident Representative on risk vs. benefits of the relationship, what is consented by both parties, and any safety information needed. The Education provided will be documented in the clinical record and the care plan updated.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 49907 Based on interview and record review, the facility failed to consistently and accurately reconcile narcotic medication counts in accordance with professional standards of practice for 1 of 3 residents (R2) reviewed for narcotic medication in a sample of 8. The findings include: R2's facility Initial Report dated 8/20/24 documents in part: The purpose of this letter is to notify The Department of a possible drug diversion. It was noted that resident Received his 8am dose of morphine but when the nurse went to give the 10 am dose the morphine could not be located. All notifications have been made. The facility has initiated an investigation into the matter. A final report will follow. R2's facility Final Report dated 8/26/24 documents in part an undated and untimed interview with V11 (LPN/Licensed Practical Nurse). V11 stated she stayed over from midnight shift to help pass the back half of 300 hall medications. V11 stated she and V4 (LPN) counted the narcotics for the front part of the hallway but not the back because she was still using the cart to pass medications. V11 stated R2's narcotic medication was on the cart for the back half of the hall. V11 stated she gave V4 the keys for the cart for the back half between 9:00am and 9:15am and they did not perform a count. On 10/9/24 at 03:15pm, V4 (LPN) stated there was no narcotic count completed between himself and V11 (LPN) after he took over the med cart. V4 stated he counted by himself at one point, and everything was fine. On 10/8/24 at 12:03pm, V5 (LPN) stated count should be done anytime a nurse is taking over responsibility of a med cart from another nurse. On 10/9/24 at 10:07am, V7 (RN/Registered Nurse) stated count should be done anytime you are assuming responsibility from someone else for those medications. On 10/09/24 at 2:20pm, V2 (DON) stated that narcotics should be counted any time that a nurse is taking over responsibility for the cart and before anyone leaves. A facility document titled, Employee corrective action form for V4 dated 8/20/24 documents in part a failure to follow departmental policies and procedures, by not counting narcotics with nurse from previous shift and not properly storing narcotics after administration. A facility document titled, Employee corrective action form for V11, dated 08/20/24 documents in part a failure to follow departmental policies and procedures, by not counting narcotics with oncoming nurse. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility controlled substance policy documents in part; The persons performing the inventory will sign to verify that the inventory was done. All controlled substances are to be counted every shift. The count is to be performed by the oncoming licensed nurse here applicable and the off-going licensed nurse where applicable.